Summary Plan Document

Supplemental 65 - Medicare Primary Plan

Group Number: 707837
Effective Date: July 1, 2011

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Introduction

We are pleased to provide you with this Summary Plan Document (SPD). This SPD describes your Benefits, as well as your rights and responsibilities, under the Plan.

How to Use this Document

We encourage you to read your SPD and any attached Riders and/or Amendments carefully.

Many of the sections of the SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your SPD and any attachments in a safe place for your future reference.

Please be aware that your Physician does not have a copy of your SPD and is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this SPD is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in Section 9: Glossary of Defined Terms. You can refer to Section 9 as you read this document to have a clearer understanding of your SPD.

When we use the words "we", "us", and "our" in this document, we are referring to the Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in Section 9: Glossary of Defined Terms.

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Customer Service and Claims Submittal

Please make note of the following information that contains Claims Administrator department names and telephone numbers.

Customer Service Representative (questions regarding Coverage): As shown on your ID card.

Claims Submittal Address:

UnitedHealthcare Insurance Company

Attn: Claims

P. O. Box 740800

Atlanta, Georgia 30374-0800

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

UnitedHealthcare Insurance Company

P. O. Box 30573

Salt Lake City, Utah 84130-0573

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Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Maximum Plan Benefit.
- Covered Health Services. We will cover the Deductibles and Copayments for the following Health Services covered by Medicare.

Accessing Benefits

This plan provides supplemental coverage for Medicare recipients. You can choose to receive Benefits from any Medicare-participating Physician or provider.

You should show your identification card (ID card) every time you request health care services so that the provider will know that you are enrolled under the Plan.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Plan is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 7: When Coverage Ends occurs.

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- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

Special Note Regarding Medicare

You are enrolled for Medicare on a primary basis (Medicare pays before we pay Benefits under the Plan). Since Medicare is the primary payer, we will pay as secondary payer as described in Section 6: Coordination of Benefits. You are not required to notify the Claims Administrator before receiving Covered Health Services.

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Payment Information

Payment Term	Description	Amounts
Maximum Plan Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Plan.	No Maximum Plan Benefit.

Benefit Information

We will cover the Deductibles, Copayments and Coinsurance relating to the following Medicare Eligible Expenses:

Description of Covered Health Service

1. Ambulance Services

We will pay the Deductible, Copayment, and Coinsurance required under Medicare for Medicare-Eligible expenses relating to a private ground and municipal ambulance services. Private ground and municipal ambulance services are considered a Part B eligible expense to the extent they are considered Medicare-Eligible expenses.

2. Blood Services

We will pay the replacement costs, if any, required under Medicare Part A or Part B for the first three (3) pints of blood (or equivalent quantities of packed red blood cells as defined under federal regulations) unless the blood is replaced in accordance with federal regulations.

3. Cancer Drugs

We will pay the Deductible, Copayment and Coinsurance required under Medicare for Medicare-Eligible Expenses relating to specific cancer drugs. Please contact Medicare for more information.

Description of Covered Health Service

4. Chiropractic Treatment

We will pay the Deductible, Copayment and Coinsurance required under Medicare for Medicare-Eligible expenses relating to chiropractic services for manipulation of the spine to correct a subluxation (when one or more bones of your spine moves out of position). Routine care is not covered.

5. Dental Services

We will pay the Deductible, Copayment, and Coinsurance required under Medicare for Medicare-Eligible dental care expenses relating to emergency stabilization at an emergency facility. Note that Medicare does not cover routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, or dentures.

6. Diabetes Supplies

We will pay the Deductible, Copayment, and Coinsurance required under Medicare for Medicare-Eligible expenses relating to certain diabetes services and supplies.

7. Durable Medical Equipment

We will pay the Deductible, Copayment, and Coinsurance required under Medicare for Medicare-Eligible expenses relating to durable medical equipment, including durable medical equipment dispensed as part of a home health program.

Description of Covered Health Service

8. Emergency Health Services

We will pay the Deductible, Copayment and Coinsurance required under Medicare for Medicare-Eligible expenses related to emergency care.

9. Home Health Care

We will pay the Deductible, Copayment, and Coinsurance required under Medicare for Medicare-Eligible expenses related to home-health care.

10. Hospital - Inpatient

We will pay the inpatient deductible required by Medicare for Medicare-Eligible expenses relating to inpatient hospital services for the first sixty (60) days of hospitalization for each Benefit Period.

We will pay the Copayment required by Medicare for Medicare-Eligible expenses relating to inpatient hospital services for the 61st through 90th days of hospitalization per Benefit Period.

Lifetime Reserve:

If you are hospitalized more than ninety (90) days, we will pay the Copayment required by Medicare for Medicare-Eligible Expenses relating to inpatient hospital expenses for sixty (60) additional days of hospitalization ONCE in your lifetime.

Upon exhaustion of all Medicare Hospital inpatient coverage including the above lifetime reserve days, we will pay Benefits for up to ninety percent (90%) of all Medicare Part A – Eligible Expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred and sixty-five (365) days.

Note: This benefit provides coverage for a semi-private room.

11. Mental Health and Substance Abuse Services - Outpatient

We will pay the Deductible and Copayment required under Medicare for Medicare-Eligible expenses relating to mental health services and substance abuse services - outpatient.

12. Mental Health and Substance Abuse Services - Inpatient and Intermediate

We will pay the Deductible and Copayment required under Medicare for Medicare-eligible expenses relating to mental health services and substance abuse services – inpatient and intermediate.

Benefit is limited to 190 days combined for mental health and substance abuse care in a specialty psychiatric hospital in a lifetime.

Description of Covered Health Service

13. Outpatient Hospital Services, Diagnostic Laboratory, and X-Ray Services

We will pay the Deductible and Copayment required by Medicare for Medicare-Eligible expenses relating to outpatient hospital services, diagnostic laboratory, and x-ray services.

14. Professional Fees for Physician's Services

We will pay the Deductible and Copayment required under Medicare for Medicare-Eligible expenses relating to inpatient and outpatient physician services, including non-routine and home visits.

Medicare covers a one-time "Welcome to Medicare" preventive exam within the first 12 months you have Part B. Once you have Part B for longer than 12 months, Medicare will cover a yearly "Wellness" exam. However, your first "Wellness" exam cannot take place within 12 months of your "welcome to Medicare" physical exam,

15. Prosthetic/Orthotic Devices

We will pay the Deductible and Copayment required under Medicare for Medicare-Eligible expenses relating to prosthetic/orthotic devices.

Description of Covered Health Service

16. Reconstructive Procedures

We will pay the Deductible and Copayment required under Medicare for Medicare-Eligible expenses relating to Reconstructive Procedures

17. Rehabilitation Services - Outpatient Therapy

We will pay the Deductible and Copayment required under Medicare for Medicare-Eligible expenses relating to rehabilitation services-outpatient therapy, including any Medicare-Eligible expenses for physical therapy, occupational therapy, cardiac therapy, and speech-language therapy services.

18. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

We will pay the Deductible and Copayment required under Medicare for Medicare-Eligible expenses relating to skilled nursing facilities.

You are covered for the first 100 days per Benefit Period. You must meet Medicare's requirements including having been in a Hospital for at least three (3) days and entered in a Medicare approved facility within thirty (30) days after leaving the hospital.

Non-skilled and custodial care are not covered.

Description of Covered Health Service

19. Transplantation Services

We will pay the Deductible and Copayment required under Medicare for Medicare-Eligible expenses relating to transplant services.

We will pay the deductible and copayment required under Medicare for oral immunosuppressive drug therapy for transplant patients in a Medicare-certified facility.

Note: You are NOT covered for outpatient drugs (other than immunosuppressive drugs and certain cancer drugs covered by Medicare).

20. Vision Services

We will pay the Deductible and Copayment required under Medicare for Medicare-Eligible expenses relating to non-routine vision care. (Note that Medicare does not cover routine eye care.)

Covered Health Services include one pair of eyeglasses with standard frames after cataract surgery that includes an intraocular lens.

21. Further Benefits: Accident or Emergency Services Received Outside the United States

We will pay for health care services received during the first 60 days of travel outside of the United States if the services:

(a) are required due to an accident or medical emergency; AND

(b) would have been covered by Medicare as Medicare-Eligible Expenses had the accident or medical emergency occurred in the United States.

No coverage is provided if you reside outside of the United States.

Because this benefit is not covered by Medicare, we have delegated to the Claims Administrator the discretion and authority to determine on our behalf whether the service is a Covered Health Service and how the Medicare-Eligible expense will be determined and otherwise covered under the Plan.

Section 2: What's Not Covered--Exclusions

We will not pay Benefits for the following services:

(a) Health services not covered by Medicare, except for accident or emergency services received outside the United States as set forth in Section 1;

(b) Health services not listed in Section 1;

(c) Services that are not supplemental to Medicare-Eligible Expenses;

(d) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

(e) Cosmetic surgery not directly related to an injury, infection, or disease covered under this agreement;

(f) Hearing aids (including any examinations and fittings for these devices);

(g) Services resulting from war or act of war (whether declared or undeclared); participation in a felony or riot; suicide (while sane or insane), attempted suicide, intentionally self-inflicted injury; aviation;

(h) Services You receive when there is no charge to You;

(i) Illegal drugs;

(j) Marital counseling;

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(k) Routine physical examinations not covered by Medicare;

(l) Dental care;

(m) Routine and refractive eye examinations or eyeglasses;

(n) Outpatient prescription drugs (other than immunosuppressive drugs and certain cancer drugs covered by Medicare);

(o) Facility charges for medical emergency and trauma services for which Medicare has denied payment;

(p) Oral surgery.

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Section 3: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person must complete an enrollment form. You must have both Medicare Part A and Medicare Part B to enroll in this Plan. The Plan Administrator or its designee will give the necessary forms to you, along with instructions about submitting your enrollment form and any required contribution for coverage. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in

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accordance with the terms of the Plan until the date such confinement or treatment ends

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When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period	Eligible Persons may enroll themselves.	Coverage begins on the date identified by the Plan Administrator, if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 31 days of the date the Eligible Person becomes eligible to enroll.
Open Enrollment Period	Eligible Persons may enroll themselves.	The Plan Administrator determines the Open Enrollment Period. Coverage begins on the date identified by the Plan Administrator if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible to enroll.
New Eligible Persons	New Eligible Persons may enroll themselves.	Coverage begins on the date of retirement if the Plan Administrator receives the properly completed enrollment form and any required contribution for coverage within 31 days of the date the new Eligible Person becomes eligible to enroll and if the Participant pays any required contribution to the Plan Administrator for Coverage. If you or your dependents fail to enroll at this time, you cannot enroll in the Plan unless you do so through an Open Enrollment Period or a Special Enrollment Period.

Special Enrollment Period

An Eligible Person may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

A special enrollment period applies for an Eligible Person who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including, without limitation, legal separation divorce, death, termination of employment, or a reduction in the number of hours of employment,
  - The employer stopped paying a contribution.
  - In the case of COBRA continuation coverage, the coverage ended.

Missed Initial Enrollment Period or Open Enrollment Period. Coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

Section 4: How to File a Claim

Filing a Claim for Benefits

When you receive Covered Health Services, you or your health care provider are responsible for requesting payment from us. In most cases, Medicare Part B claims are submitted to us electronically by you Medicare carrier. Your Explanation of Medicare Benefits (EOMB) will indicate if your Medicare carrier has submitted a claim to us on your behalf. You must file the claim in a format that contains all of the required information, as described below.

You must submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be invalidated or reduced, in our discretion. This time limit does not apply if you are legally incapacitated or if extenuating circumstances apply. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the participant. But the Claims Administrator will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.

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Required Information

When you request payment of Benefits from the Claims Administrator, you must provide all of the following information:

A. The Medicare EOMB for Medicare Eligible Expenses

B. The Subscriber's name and address.

C. The patient's name and age.

D. The number stated on your ID card.

E. The name and address of the provider of the service(s).

F. A diagnosis from the Physician.

G. An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.

H. The date the Injury or Sickness began.

I. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

Benefits are paid within the time frames shown below after the Claims Administrator receives a request for payment that includes all required information.

- 30 days after receipt of a request submitted by electronic means.
- 40 days after receipt of a request submitted by other than electronic means.

Requests for payment that include all required information which are not paid within these time frames will include an overdue payment of interest at the rate of 12% per annum.

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Medicare Cross-Over is the process by which Medicare automatically forwards medical claims to the Claims Administrator for processing. Medicare Cross-Over is available to any Medicare-primary State of Rhode Island Participant. A Provider will submit your claim directly to Medicare. That is, Medicare pays first, then claims are submitted electronically to the Claims Administrator. It is available to both Participants and their Medicare-eligible dependents, if they do not have group coverage from another source. A completed enrollment form (which is available from your Plan Administrator) is necessary to enroll in the Medicare Cross-Over program.

This Medicare Cross-Over Program applies to Medicare Part B and Durable Medical Equipment claims. Medicare Part A expenses are not included. As a State of Rhode Island plan Participant, there is no fee to you for the Medicare Cross-Over service. You may receive an Explanation of Medicare Benefits (EOMB) from your Medicare carrier which will tell you that your claim has been forwarded to your "secondary carrier". (The EOMB may refer to your "secondary carrier" rather than the Claims Administrator specifically.) If this message does not appear, you will have to submit the claim to the Claims Administrator yourself.

If your Medicare carrier does not send you an EOMB, you will know that your claim was crossed over if the Claims Administrator's Explanation of Benefits includes a summary of Medicare's benefits. You may also call the State of Rhode Island plan service number at 1-866-202- 0434 any time you have a question.

Physician's are required to file claims only with Medicare. Even if your Physician does send the bill directly to the Claims Administrator, the claim cannot be processed under the State of Rhode Island plan until Medicare's payment information is received.

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Certain claims will still need to be submitted to the Claims Administrator including Medicare Part A claims. If there are remaining expenses to be paid to the provider, please submit the Medicare Explanation of Benefits (EOB) and the Claims Administrator's Medical Reimbursement Claim Form to the address on the claim form. If you would like the Claims Administrator to pay the provider directly, please indicate this on the claim form. If you do not tell the Claims Administrator to pay the provider, the reimbursement will go to you, not the provider. You may obtain a Medical Reimbursement Claim form from the Claims Administrator by printing one from www.myuhc.com, or by calling the Claims Administrator 's State of Rhode Island Customer Service Unit at 1-866-202-0434.

If you have any questions about anything involving your State of Rhode Island plan medical claim, call the Claims Administrator's State of Rhode Island Customer Service Unit at 1-866-202-0434. If you have any questions about your primary claim, you should call Medicare.

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Section 5: Questions, Complaints, Appeals

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You have a complaint.

Medicare Related Questions, Complaints Appeals

What to DO First.

If you are dissatisfied with the quality of care you receive for services covered by Medicare, or if you have concerns about any aspect of your Medicare eligible medical treatment, please contact Medicare.

If you disagree with a full or partial denial of a Medicare payment, you may dispute the decision through the Medicare appeals process. To start this process, follow the directions given in the letter you received from Medicare regarding the denial. **Medicare questions, complaints and appeals are not handled by this Plan**.

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If you have questions or concerns regarding benefits under this Plan, follow the process set forth below.

Other Questions, Complaints, Appeals – Contact the Claims Administrator's Customer Service Department

The telephone number is shown on your ID card.

Customer Service representatives are available to take your call during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail. A Customer Service representative will return your call. If you would rather send your complaint to us in writing at this point, the Customer Service representative can provide you with the appropriate address. You will receive an acknowledgement letter within ten (10) business days of the Grievance and Appeal Unit's receipt of your written complaint or administrative appeal. If someone is filing a complaint on your behalf, you must send us a notice that the person has the authority to receive information about you on your behalf. This notice must be signed by you.

What to Do Next

If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint or file a verbal complaint on your behalf. The Claims Administrator will notify you of the decision regarding your complaint within 31 business days of receiving it. Your determination letter will provide you with information regarding the determination and your rights to further review if you are not satisfied with the outcome of the review and determination.

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What to Do if You Disagree with the Decision

If you disagree with the decision after following the above steps, you can ask for your complaint to be formally reconsidered.

If the complaint relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.
- The Medicare EOMB for Medicare Eligible Expenses
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any new information to support your request for claim payment.

A committee will be appointed to resolve or recommend the resolution of the complaint. If your complaint is related to clinical matters, the committee will include health care professionals who did not make the first determination. Medical experts may be consulted or may participate in the complaint resolution process.

Level 1 Review

You may request a Level 1 review of any matter subject to medical appeal by making a request for such review to us within sixty (60) calendar days of the initial determination letter. You may request this review by calling Customer Service, but we strongly suggest you submit your request in writing to ensure your request is accurately reflected.

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You will receive notification of the determination on a Level 1 review within fifteen (15) business days, or within twenty-one (21) business days if you are notified verbally within fifteen (15) business days following the receipt of all necessary medical information to conduct a review. The combined time to attempt to obtain medical information and complete the review will not exceed forty-five (45) business days from the receipt of your request for a Level 1 review. If you are requesting reconsideration (Level 1 review) of a service that was denied after you already obtained the service, then you will receive written notification of the determination within thirty (30) business days of the receipt of all necessary medical information.

Level 2 Review

You may request a Level 2 appeal review (preferably in writing) if the denial was upheld during the Level 1 review process. Your Level 2 appeal review will be reviewed by a provider in the same specialty as your treating provider. You must submit your request for a Level 2 appeal review within sixty (60) calendar days of the date of the reconsideration determination letter. Upon request for a Level 2 review, you will be provided with the opportunity to inspect the medical file and add information to the file. You will receive written notification of a determination on a Level 2 review within fifteen (15) business days, or within twenty-one (21) business days if notified verbally within fifteen (15) business days following the receipt of all necessary medical information to conduct a review. The combined time to attempt to obtain medical information and to complete the review will not exceed forty-five (45) business days from the receipt of your request for a Level 2 review. If the service you are requesting review of was denied after you already obtained the service (retrospectively), you will receive written notification of the determination within thirty (30) business days of the receipt of all necessary medical information.

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External Review

If you remain dissatisfied with the determination of the internal review processes (Level 1 and Level 2), you may request an external review by an outside agency. All such external reviews will be conducted in accordance with applicable state laws and regulations, including the Department of Health Rules and Regulations for the Utilization Review of Health Care Services. Information about this process will be included in the final determination letter you receive.

To request an external review, you must submit a written request to the Claims Administrator within sixty (60) calendar days of your receipt of the medical appeal denial notification. You will be permitted to select the external appeal agency that will perform the external appeal from a list of Department of Health approved agencies. You will be responsible for fifty percent (50%) of the charges and fees from the external agency and we will pay the remaining fifty-percent (50%). However, if the external appeal agency overturns the denial determination, you will be reimbursed for your half of the cost of the review agency's review. For all such appeals, the external appeal agency will notify you of its determination within ten (10) business days of the agency's receipt of the information.

Judicial Review

If you are dissatisfied with the final decision of the external appeal agency, you are entitled to a final review (A Judicial Review). This review will take place in an appropriate court of law.

Note: Once a member or provider receives a decision at one of the several levels of appeal (Level 1, Level 2, External and Judicial), no other party (provider or the member) may ask for an appeal at the same level again, unless additional information that could impact such decisions can be provided.

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Grievances Unrelated to Claims

We encourage you to discuss any complaint that you may have about any aspect of your medical treatment with the health care provider that furnished the care. In most cases, issues can be more easily resolved when they are raised when they occur. If however, you remain dissatisfied or prefer not to take up the issue with your provider, you may access the complaint and grievance procedures.

You may access the complaint and grievance procedures if you have a complaint about the service or regarding one of the employees of the Claims Administrator. In order to initiate a grievance, please call the Customer Service Department at the number on the back of your ID card. The Customer Service Department will log in your call and begin working towards the resolution of your complaint.

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Section 6: Coordination of Benefits

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating benefits.

This plan will pay the copayment, coinsurance and deductible for Medicare eligible expenses, unless noted otherwise in the specific benefit.

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When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one benefit plan.

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

1. "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
   a. "Coverage Plan" includes: (1) Group insurance or group-type coverage whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage. (2) Coverage under a governmental plan, or coverage required to be provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

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b. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under a. or b. above is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

2. The order of benefit determination rules determine whether this Coverage Plan is a "Primary Coverage Plan" or "Secondary Coverage Plan" when compared to another Coverage Plan covering the person.

   When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the Primary Coverage Plan's benefits.

3. "Allowable Expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an Allowable Expense. Dental care, routine vision care, outpatient prescription drugs, and hearing aids are examples of expenses or services that are not Allowable Expenses under the Plan. The following are additional examples of expenses or services that are not Allowable Expenses:

   a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is determined by a Physician to medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.

   b. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

   c. If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   d. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.

   e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

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4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.
5. "Closed Panel Plan" is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.

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C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.

D. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.
2. Child Covered Under More Than One Coverage Plan. The order of benefits when a child is covered by more than one Coverage Plan is:
   a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
      1) The parents are married;
      2) The parents are not separated (whether or not they ever have been married); or
      3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

   If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

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b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.

c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

   1) The Coverage Plan of the custodial parent;
   2) The Coverage Plan of the spouse of the custodial parent;
   3) The Coverage Plan of the noncustodial parent; and then
   4) The Coverage Plan of the spouse of the noncustodial parent.

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D.1.
4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.
6. If a husband or wife is covered under this Coverage Plan as a Participant and as an Enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Coverage Plan, this means the Participant's benefit will pay first.
7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

E. A group or individual automobile contract that provides medical, no-fault or personal injury protection benefits or a homeowner's policy that provides medical benefits coverage shall provide primary coverage.

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Effect on the Benefits of this Plan

A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. The difference between the benefit payments that this Coverage Plan would have paid had it been the Primary Coverage Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by this Coverage Plan to pay any Allowable Expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Coverage Plan will:

1. Determine its obligation to pay or provide benefits under its contract;
2. Determine whether there are any unpaid Allowable Expenses during that claim determination period.

If there is a benefit reserve, the Secondary Coverage Plan will use the Covered Person's benefit reserve to pay up to 100 percent of total Allowable Expenses incurred during the claim determination period. At the end of the claim determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.

C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

— The person is entitled but not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

— The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.

— The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.

— The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.

— The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

To continue reading, go to right column on this page.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Coverage Plan and other Coverage Plans. The Plan Administrator may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming benefits.

The Plan Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Coverage Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

To continue reading, go to left column on next page.

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Coverage Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made is more than should have been paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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Section 7: When Coverage Ends

This section provides you with information about all of the following:

- Events that cause coverage to end.
- The date your coverage ends.

General Information about When Coverage Ends

We may discontinue this benefit Plan and/or all similar benefit plans at any time.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive for medical conditions that occurred before your coverage ended.

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Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table:

Ending Event	What Happens
The Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage ends on the date you are no longer eligible to be a Participant or the date you cease to be covered under either Part A or Part B of Medicare. Please refer to Section 9: Glossary of Defined Terms for a more complete definition of the terms "Eligible Person" and "Participant".
The Claims Administrator Receives Notice to End Coverage	Your coverage ends on the date the Claims Administrator receives written notice from us instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Participant that coverage has ended on the date the Plan Administrator identifies in the notice:

Ending Event	What Happens
Fraud, Misrepresentation or False Information	Fraud or misrepresentation, or because the Participant knowingly gave us or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent. During the first two years the Plan is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Plan. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement regarding eligibility or status as a Dependent.
Material Violation	There was a material violation of the terms of the Plan.
Improper Use of ID Card	You permitted an unauthorized person to use your ID card, or you used another person's card.
Failure to Pay	You failed to pay a required contribution.
Threatening Behavior	You committed acts of physical or verbal abuse that pose a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons.

Section 8: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning the Plan.

Plan Document

This Summary Plan Document presents an overview of your Benefits. In the event of any discrepancy between this Summary Plan Document and the official Plan Document, the Plan Document shall govern.

Relationship with Providers

This Plan provides supplemental coverage for Medicare recipients. Providers are not our agents or employees. Nor are they agents or employees of the Claims Administrator. Neither we nor any of our employees are agents or employees of providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits. Providers are independent practitioners who run their own offices and facilities. Providers are not our employees or employees of the Claims Administrator; nor do we have any other relationship with providers such as principal-agent or joint venture. Neither we nor the Claims Administrator are liable for any act or omission of any provider.

To continue reading, go to right column on this page.

The Claims Administrator is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

We are solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The payment of Benefits.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider and complying with Medicare requirements relating to participating providers.
- You must decide if any provider treating you is right for you. This includes providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and us is that of employer and Participant, as defined in the Plan.

To continue reading, go to left column on next page.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Plan

Plan Amendments and Riders are effective on the date specified.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Benefits listed in Section 1 of this Summary Plan Document will change automatically if the related Medicare-Eligible expenses change. The Claims Administrator will give you written notice and a brief description of the change(s) at least thirty (30) days prior to the effective date. Subscriber fees may be increased or decreased to reflect any change of Benefits under this Summary Plan Document.

Any change or amendment to or termination of the Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of a termination), whether prospective or retroactive, to the Plan, in accordance with the procedures established by us. Covered Persons will receive notice of any material modification to the Plan. No one has the authority to make any oral modification to the SPD.

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Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times we or the Claims Administrator may need additional information from you. You agree to furnish us and/or the Claims Administrator with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it, we may delay or deny payment of your Benefits.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us or the Claims Administrator with all information or copies of records relating to the services provided to you. We or the Claims Administrator have the right to request this information at any reasonable time. This applies to all Covered Persons, whether or not they have signed the Participant's enrollment form. We and the Claims Administrator agree that such information and records will be considered confidential.

To continue reading, go to left column on next page.

We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we or the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as the Plan Administrator.

Workers' Compensation not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement, as defined below.

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Right to Subrogation

The right to subrogation means the Plan is substituted to any legal claims that you may be entitled to pursue for Benefits that the Plan has paid. Subrogation applies when the Plan has paid Benefits for a Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your behalf relating to any Sickness or Injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Third Parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- The Plan Sponsor.
- Any person or entity who is or may be obligated to provide you with benefits or payments under:
  - Underinsured or uninsured motorist insurance.
  - Medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise).
  - Workers' compensation coverage.

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— Any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- The Plan may enforce its subrogation and reimbursement rights regardless of whether you have been "made whole" (fully compensated for your injuries and damages).
- You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - — Complying with the terms of this section.
  - — Providing any relevant information requested.
  - — Signing and/or delivering documents at its request.
  - — Appearing at medical examinations and legal proceedings, such as depositions or hearings.
  - — Obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

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- If you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- You will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- The Plan's rights will not be reduced due to your own negligence.
- The Plan may file suit in your name and take appropriate action to assert its rights under this section. The Plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name.
- In case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.
- Your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.

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- If a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

If you want to bring a legal action against us or the Claims Administrator you must do so within three (3) years from the expiration of the time period in which a request for reimbursement must be submitted, or you lose any rights to bring such an action against us or the Claims Administrator.

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You cannot bring any legal action against us or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against us or the Claims Administrator you must do so within three (3) years of the date you are notified of our final decision on your appeal, or you lose any rights to bring such an action against us or the Claims Administrator.

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Section 9: Glossary of Defined Terms

This section:

- Defines the terms used throughout this SPD.
- Is not intended to describe Benefits.

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when signed by us or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Benefit Period - A benefit period begins the day you go to a Hospital or Skilled Nursing Facility. The benefit period ends when you have not received Hospital or Skilled Nursing care for 60 days in a row. If you go into the Hospital after one benefit period has ended, a new benefit period begins.

Benefits - your right to payment under the Plan for coinsurance, deductibles and copayments associated with Medicare and listed in Section 1 of this Summary Plan Document. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this SPD and any attached Riders and Amendments.

Claims Administrator - the company (including its affiliates) that provides certain claim administration services for the Plan.

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Copayment - the charge Medicare requires you to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Medicare-Eligible Expenses.

Covered Health Service(s) - those health services covered by Medicare.

Covered Person - the Participant, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Eligible Expenses - for Covered Health Services incurred while the Plan is in effect, Eligible Expenses include Deductibles and Copayments.

Eligible Person - a former employee of the Plan Sponsor who has retired under the Plan, is eligible for Medicare Part A and enrolled in Medicare Part B, and is otherwise eligible to enroll in the Plan, as determined by the Plan Sponsor.

Initial Enrollment Period - the initial period of time, as determined by the Plan Administrator, during which Eligible Persons may enroll themselves under the Plan.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

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Medicare - Parts A, B, and C of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves under the Plan, as determined by us.

Participant - an Eligible Person who is properly enrolled under the Plan. The Participant is the person on whose behalf the Plan is established.

Plan - UHC Supplemental 65 Plan for State of Rhode Island Health Benefit Plan.

Plan Administrator - State of Rhode Island or its designee.

Plan Sponsor - State of Rhode Island. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Rider - any attached written description of additional Covered Health Services not described in this SPD. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the Rider.

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